



U.S. Agency for
International
Development

Bureau for
Global Health

COUNTRY PROFILE

HIV/AIDS

INDONESIA

Indonesia stands at a crossroads in its HIV/AIDS epidemic. Like several of its Asian neighbors, Indonesia had low HIV prevalence until the late 1990s, when the situation began to change rapidly. Massive economic and political disruption in recent years has produced dramatic changes in Indonesia's national-risk environment. The country is experiencing new, rapidly developing sub-epidemics in several provinces and communities. Indonesia now perceives HIV/AIDS as a serious threat to its national development and prosperity.

Estimated Number of Adults and Children Living with HIV/AIDS (end 2002)	90,000–130,000
Total Population (end 2001)	214,840,000
Adult HIV Prevalence (end 2001)	0.1%
HIV-1 Seroprevalence in Urban Areas (end 2000)	
Population most at risk (sex workers and clients, patients seeking treatment for a sexually transmitted infection, or other persons with known risk factors)	0.2%
Population least at risk (pregnant women, blood donors, or other persons with no known risk factors)	0.0%

Sources: UNAIDS, U.S. Census Bureau, USAID/Indonesia

In just a few years, Indonesia's HIV/AIDS classification, according to the Joint United Nations Programme on HIV/AIDS, has moved from "low level" to "concentrated epidemic." As recently as 1997, HIV prevalence was estimated to be less than 1 percent among traditional at-risk populations, including commercial sex workers, men who have sex with men, and injecting drug users. Beginning in 1998, surveillance reports began to show increased prevalence among these groups in a growing number of provinces. Among female sex workers, 2001 prevalence rates ranged from 7 percent in Kotim in Central Kalimantan to 26.5 percent in Merauke, Papua. Although data for men who have sex with men are limited, a study completed in August 2002 found an infection rate of 21.7 percent among *waria* (transvestites) in urban Jakarta. Among Indonesia's newest risk group—young, urban, injecting drug users—prevalence rates have reached 48 percent in Jakarta, 45 percent in West Java, and 53 percent in Bali.

Low levels of condom use and high levels of sexually transmitted infections among at-risk populations suggest that the epidemic could spread rapidly not only in commercial sex establishments but also between injecting drug users and their sexual partners. Despite extensive behavior-change efforts and social marketing of condoms, condom use remains low among individuals with multiple sex partners

and appears to have even declined in some urban areas among female sex workers. At the same time, sexually transmitted infections—which increase the risk of HIV transmission—remain very high. Among female sex workers in Jakarta, for example, rates of sexually transmitted infections increased from 23 percent in 1996, to 53 percent in 2000. Lifetime syphilis exposure among *waria* in Jakarta increased from 35 percent in 1995, to 62 percent in 2002.



Map of Indonesia: PCL Map Collection, University of Texas

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Additional risk factors that could contribute to a sudden, rapid spread of HIV include:

- A vast unreported sex industry (formal and informal, male and female)
- Limited clinic and laboratory services for sexually transmitted infections
- A highly mobile population
- Rapidly expanding injecting drug use
- The aftermath of a major economic crisis (including women in search of survival opportunities and increasing numbers of children and families living and working on the streets)
- Recent government decentralization with a changing, but not yet defined, division of health care responsibility among central, provincial, and district governments

NATIONAL RESPONSE

The first case of HIV/AIDS in Indonesia was detected in 1987. In 1994, Indonesia developed an initial national AIDS strategy and created a National AIDS Commission. The strategy promoted a national effort to control HIV/AIDS, carried out by government, nongovernmental organizations, the private sector, and communities through multisectoral collaboration. Its focus was to mobilize families and communities to protect themselves from HIV infection and to ensure that appropriate treatment, care, and support services were made available to those who were infected and their families.

In July 2003, the Cabinet endorsed the second National AIDS Strategy (2003–2007), which reinforces the essential role of prevention as the core of Indonesia's HIV/AIDS program while also recognizing the urgent need for scaling up treatment, care, and support. The strategy also stresses the importance of surveillance for HIV/AIDS and sexually transmitted infections; operational studies and research; creation of an enabling environment (through legislation, advocacy, capacity building, and anti-discrimination efforts); coordination among stakeholders; and an emphasis on sustainability. The new strategy gives donors a clear policy framework within which to work.

The National AIDS Commission brings together senior decision-makers from various social and economic sectors and includes representatives of affected communities, religious leaders, local nongovernmental organizations, and others. Similar committees have been formed and some are active at the provincial and district levels. The National AIDS Commission will work with local committees to guide the response to HIV/AIDS in locally appropriate ways under the decentralization laws that became effective in 2001. In this role, the National Commission has identified ten priority programs: 1) information, education, and communication; 2) prevention; 3) testing and counseling; 4) treatment and care; 5) education and training for health workers; 6) research and development; 7) surveillance; 8) international cooperation; 9) program institutionalization; and 10) laws and regulations. HIV is viewed as a multisectoral rather than simply a health issue.

In September 2002, the Ministry of Health convened a workshop to estimate national HIV/AIDS prevalence rates. Participants included representatives from government, nongovernmental organizations, and the university and community sectors. Donors, such as UNAIDS, the United States Agency for International Development (USAID), and the World Health Organization, provided technical assistance. By consensus of the participating parties, the level of HIV/AIDS at the end of 2002 was estimated to be somewhere between a low of 90,000 and a high of 130,000 cases.

USAID SUPPORT

To address the growing HIV/AIDS prevalence rate in Indonesia, USAID allocated \$9.0 million to HIV/AIDS activities in Fiscal Year 2003, a significant increase from \$4 million in Fiscal Year 2001.

From 1994 to 1999, USAID supported the HIV/AIDS Prevention Project, a collaborative activity of USAID and the Ministry of Health. During Indonesia's economic and political turmoil, USAID/Indonesia's health effort focused on protecting the health of the country's most vulnerable women and children. In 2000, as Indonesia's economy began to stabilize, USAID developed a new HIV/AIDS strategy within the larger context of ensuring health as decentralization proceeds. HIV/AIDS and other infectious diseases were a major component in the overall strategy that has three main objectives: 1) improving the policy environment for reproductive and child health, HIV/AIDS, and other infectious diseases; 2) strengthening health services to improve access, quality, and sustainability; and 3) empowering women, families, and communities to take responsibility for improving health.

Since August 2000, USAID/Indonesia has supported a five-year, \$35.3 million Sexually Transmitted Infection and HIV/AIDS Prevention Support Program that works in partnership with the Ministry of Health, local government offices, and civil society organizations. Known locally as “*Aksi Stop AIDS*” or “*ASA*” (ASA means “hope” in the Indonesian language), the program supports intensive interventions among female sex workers, men who have sex with men, injecting drug users, and the clients of sex workers (the main epidemiological “bridge” to the general population). The goal is to keep HIV prevalence low in these most-at-risk populations, thereby delaying and perhaps preventing the spread of HIV throughout the vast Indonesian archipelago. The first phase of this strategy (conducted in 2000–2002) focused on five geographic areas where the local epidemic was clearly expanding: Papua, Metropolitan Jakarta, East Java (Surabaya/Malang), North Sulawesi (Manado/Bitung), and Riau (Pekan Baru and the Riau Islands). In the second phase, five additional target areas are being added: West Java (Bandung), North Sumatra (Medan), Central Java (Semarang), South Sumatra (Palembang), and Maluku Islands (Ambon).

The strategy for 2002–2007 involves an expanded USAID response in the ten designated sites, with particular emphasis on Papua, where a number of factors combine to make HIV especially likely to spread to the general population. The USAID strategy is consistent with the priorities of the Indonesian government and is designed to complement the activities of other donors, thus maximizing impact. It has the following main components.

Surveillance

To correct weaknesses and gaps in Indonesia’s surveillance system, USAID’s expanded strategy includes these elements:

- Strengthened surveillance capacity at the national level, while allowing flexibility at the provincial level
- Training for national- and provincial-level surveillance staff in data analysis and interpretation, along with appropriate software
- Development of policy, guidelines, and strategies to involve health officials at all levels
- Integration of sexually transmitted infection surveillance at selected sites
- Sentinel surveillance in conjunction with other health programs in high-prevalence areas
- Assistance to help national, provincial, and district-level stakeholders use and analyze data for decision-making, including prioritization, financing, and intervention planning as well as lobbying
- Integration of sexually transmitted infection surveillance and other data to create an understanding of changes in the epidemic over time
- Support for the national estimation process and the development and publication of an annual national HIV report based on the estimation process

Voluntary counseling and testing

Voluntary counseling and testing are an important entry point for both prevention and care services, as well as an effective mechanism for decreasing the effects of stigma. All provincial health laboratories are capable of performing basic HIV testing, while the logistics of moving specimens between clinics and labs remain a challenge. An aggressive effort is being made to train personnel and establish voluntary counseling and testing centers to provide counseling services where they are not available. Voluntary counseling and testing services are generally available only in a few urban areas, and there are issues related to both laboratory and human resource capacity.

USAID supported an evaluation of the HIV test kits used in-country, the establishment of national standards and procedures for testing, and the establishment of voluntary counseling and testing at each site. USAID will support the establishment of national HIV laboratory quality assurance and control programs and training to develop a competent cadre of counselors, and will strengthen the linkages between voluntary counseling and other prevention, care, and support services.

ABC Promotion

USAID behavior change interventions support a national **A**bstinence, **B**e faithful, **C**ondom (**ABC**) strategy to prevent sexual transmission among high-risk populations. The ABCs are promoted by nongovernmental organization peer educators among groups at high risk whose members often do not realize they are at risk. This activity is an important part of USAID/Indonesia’s expanded HIV/AIDS strategy, as is strengthening the private sector’s ability to market condoms for disease prevention. Specific activities in the new strategy include:

- Working with faith-based organizations and political leaders to promote messages of abstinence and fidelity

- Working collaboratively with Indonesian manufacturers and nongovernmental organizations to ensure that condoms are available where they are needed, with an expanded focus on the clients of female sex workers (including transportation workers, port workers, seafarers, police, and military) and on male sex workers
- Encouraging local government officials to institute and enforce 100 percent condom use regulations
- Encouraging condom availability in government health facilities in support of the government's strategy to promote condom use for *dual protection*, i.e., family planning and disease prevention
- Working with other donors to promote condom use among the country's rapidly growing population of injecting drug users
- Encouraging condom availability in private sector workplaces

Faith-based organizations

USAID has worked with faith-based organizations since 1996 in advocacy, capacity development, policy support, and direct interventions with specific groups most-at-risk for HIV infection. At the national level, HIV prevention activities have been strengthened through a variety of meetings, seminars, and workshops with the two major Islamic groups in Indonesia representing nearly 100 million followers, and their key religious leaders. At the local level, the socialization of prevention messages and promotion of safer sex have been supported through networking with Christian and Islamic community groups alike. Funding and technical assistance have also been provided directly to more than 28 faith-based organizations throughout the country to enable them to implement interventions targeting groups most at risk, including outreach to female sex workers, their clients, and injecting drug users; clinical services; and innovative care and support for people living with HIV/AIDS.

Capacity building

USAID works with nongovernmental organizations and national, provincial, and district AIDS commissions to expand their capacities for initiating HIV/AIDS prevention activities as well as to provide care and support to HIV/AIDS patients and their families. In response to USAID and other donor initiatives, some 200 Indonesian nongovernmental organizations are involved in HIV/AIDS activities. USAID efforts focus on building their capacity, expanding the models for mobilizing communities and focusing resources, and linking local organizations with each other and with international volunteer organizations. USAID works with national, provincial, and district AIDS commissions to clarify responsibilities among governmental levels, replicate effective models, and encourage increased budgetary resources.

Information, education, and communication

To reinforce prevention and behavior change messages, USAID supports the development and implementation of a communications strategy that includes both media campaigns directed to at-risk populations and campaigns aimed at the wider public.

Private sector

Working with five nongovernmental organization partners in Jakarta, East Java, South Sumatra, and Riau, USAID has set up prevention programs in 26 companies reaching 500,000 workers. These include businesses that employ large numbers of mobile male workers living apart from their partners. In partnership with the International Labor Organization, USAID supports the scaling up of interventions that target high-risk men through policy development and capacity building for the Ministry of Manpower, the Indonesian Employers Association, and national trade unions representing shipping, transport, and resource mining industries. The Ministry of Manpower has committed to joint training for 2,000 health and safety field inspectors in 2003–2004 and is providing technical support to the International Labor Organization for integration of HIV/AIDS awareness into all union trainings. To strengthen program implementation in companies, unions, and government departments, a manual of simple-to-use tools and guidelines for setting up HIV/AIDS programs has been developed in the local language.

Military and Police

An agreement between USAID, Ministry of Health, and the Senior Commands of the Police and the Armed Forces has laid the foundation for an integrated program of HIV/AIDS prevention interventions. Behavioral data were collected from a number of military units in April 2003. The results indicated significant levels of high-risk behavior. An agreement was also reached to develop a peer leadership intervention program. An initial training-of-trainers course, adapted from

programs used with armed forces personnel in Cambodia and countries in Africa, was run for core trainers as well as for 250 peer leaders from all branches of the services and police. Specific units that will potentially be exposed to high risks, such as those deployed on international peacekeeping missions and high-prevalence areas of Indonesia will also be prioritized. Limited sero-surveillance among specific units will be conducted along with routine behavior surveillance.

Prisons

HIV testing in prison populations in Indonesia indicates high rates of infection. Prisons are also severely overcrowded and tuberculosis is a serious problem. Adding to the problem is that a significant proportion of inmates throughout the country are incarcerated on drug-related offenses. HIV prevention initiatives in prisons are urgently needed. A working group on prisons that includes USAID partners has opened the way for a more comprehensive and integrated approach to prison interventions. Pilot HIV prevention programming in selected prisons will be implemented along with institutional strengthening for the Directorate of Correctional Institutions and the development of a joint surveillance system.

Care, support, and treatment

USAID and its partners have worked to strengthen service delivery and access through a range of models, including case management, clinical care, home care, and support groups for people living with HIV/AIDS, including buddy services. They have also been involved in and provided support for the revision and development of the National Guidelines on the Care, Support and Treatment of People Living with HIV/AIDS, under the auspices of the Ministry of Health and the World Health Organization.

The capacity to provide a clinical response to opportunistic infections and to manage antiretroviral therapy in Indonesia is still limited. Stigma and discrimination against people living with HIV/AIDS by medical staff remain high, largely from fear and misunderstanding of disease transmission. Universal precautions are rarely practiced because of lack of training, lack of belief that they work, and a lack of necessary supplies. Access to antiretroviral drugs for post-exposure prophylaxis is rarely available. First steps in improving services will require addressing all of these issues with medical directors and administrators to ensure policies, supplies, and training or refresher training are in place to assure universal precautions and positive attitudes on the part of the staff. USAID partners will provide capacity-building training preceded by universal precaution refresher training, and setting up systems for universal-precautions implementation including necessary supplies and access to post-exposure prophylaxis.

FOR MORE INFORMATION

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